EXHIBIT C

Daniel Kuhn M.D., P.C.

Integrative Neuropsychiatric Services of New York

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9.4.08

Initial Neuropsychiatric Report

Re: Gabriel Steif
DOA: 02.27.08
DOBA 04.25.37
SS# 076-36-0954
No Fault carrier – Frontier adjuster
PI Attorney – Jaroslawicz & Jaros LLC

The patient was seen for initial evaluation on 8.8.08. His initial evaluation was completes in two sessions, the second one was on 9.4.08.

The patient is a 71 year old white male, married, who works as an executive in a B&H Photo Video Store in the purchasing office.

The patient was referred by his Neurologist for a neuropsychiatric evaluation of a traumatic brain injury he suffered in a MVA on 2.28.08.

Description of the accident

The patient crossed Dyer Street and West 40ᵗʰ street, when he was hit by a bus. He suffered a direct blow to his forehead and fell down on the pavement, hitting his head in the occipital area. He lost consciousness upon impact and regained it later after arriving to the ER of Bellevue Hospital. There he was found to have a broken his right foreleg, left wrist and six ribs, two on one side and four on the other.

Medical History

Prior to his injury the patient has been healthy and well. He suffers from a mild arrhythmia. He has no history of any prior medical, psychiatric or neurological disorders. He has never been hospitalized before. He was treated for pain in his left knee fifteen years ago.

The patient denies a history of head injury, Seizure disorder, febrile convulsions, Meningitis, Encephalitis, Lyme disease, Chronic Fatigue Syndrome, or any other neurological conditions. The patient denies a history of drug or alcohol abuse.

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Neuropsychiatric Condition
The patient states that since the accident he has been mentally slower, and has difficulty focusing, attention and handling complex situations on his job.

He is distraught by the decline in his mental functioning, and finds that he is unable to function on the same level of executive competence and intellectual function as before the accident. He finds that his attention and concentration are impaired. He can not function on the same level of competence, productivity and management skills that he did prior to the accident while on the job, and therefore had to relinquish executive responsibilities and do instead a supervisory type of work. Before the accident he was the manager of the purchasing department of a major company, B&H.

He finds himself to be tired and having to take frequent break while on the job. He needs more sleep and goes to sleep earlier than usual.

He has a tingling sensation in his left fingers. When bending he has tingling sensation in his waist region bilaterally.

He can not concentrate on reading. He has been engaged in religious studies all his life and had a rigorous study routine. He states that now he has difficulty studying, although he allocate time to study every day. He still spends 2.5 hours every morning.

He reports having frequent headaches which respond to Tylenol. He has vertigo, especially when laying down – everything turns around him. He gets dizzy when getting up and has balance problems.

He denies having depressed and has no hallucinations or delusions.

Education History
The patient has a Yeshiva education. He has worked in business all his life. He was a grocery whole sale distributor for many years, and before worked in Real Estate.

Mental Status
The patient is a casually but neatly dressed. He is oriented x3. He is alert and can easily engage in conversation. He appears to have and above average IQ, and possibly a superior intelligence, which appears to be now compromised by the effects of a brain concussion, with limitation in different aspects of his cognitive function. Any decrement in IQ may still leave him in the above average level even if he has some focal and specific deficits, and also render him dysfunctional and affect his productivity and wellbeing.

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He dos not appear to be depressed, hyperactive, restless or agitated. His affect is appropriate.

An assessment of cognitive functioning appears below:

Serial Sevens: **Mildly impaired working memory** – test was done with some effort, and one error
100-7= 93, 86, 79, 72, 65, 58, 51, 43, 36, 29, 21,…14

Spell world backwards: - DLOW?   I am missing one! - **Impaired working memory.**

Memory (after 5 minute delay):   recalled 4 out of 5 items
Pen, cup, desk, tree, house
recalled - pen, cup, desk, house,

List presidents names in backward time sequence:. **Impaired long term memory**
Bush, Cl… what's' his name, his wife just ran for president…Clinton, Carter? (No) Ford was way
before that

Assessment of Memory
List Presidents in time sequence backward (long term recall)
    Digits forward: no errors

3741	3741
69136	69136
52y864	52864
247857	247857

    Digits backwards: **Impaired Concentration**

417 (714)	714	
3951 (1593)	1539?	incorrect
7284 (4827)	48..27	
93157 (75139)	7539	incorrect
38241 (14283)	1483	incorrect

Similarities: Good Conceptual capability – identifying similarity

Apple-orange:	Fruits
Dog-lion:	Animals
Eye-ear:	organs
Poem-Statue:	Art
Table-chair:	Furniture

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Proverb interpretation: Intact ability to comprehend abstract ideas.

Rome was not built in a day: Have patient, don't hurry

A bird in the hand is worth 2 in the bush: If you achieve something take it, don't think that if I get more, ill leave what I have

One swallow does not a summer make: You need more proof.

You can't tell a book by its cover: you can not tell something from the outside.

Impression
The patient suffers from impaired concentration and memory.

Diagnostic Tests
Conner's Continuous Performance Test
Neuropsychological Testing
Neurometric Brain Mapping - EEG,QEEG, EPs.

Diagnosis
Axis I - Attention and memory disorder, NOS, secondary to a TBI with LOC
          - Adjustment reaction with despondent mood, Post traumatic
          - Avoidant anxiety, Post Traumatic
Axis II - No condition
Axis III - Post Concussion Encephalopathy 310.2
          - Mild Traumatic Brain Injury with a brief Loss of Consciousness 850.11
            Multiple rib fracture; Fracture of right Tibia and left wrist.
Axis IV No significant stressors
Axis V - GAF= 60

Causal Relationship
Based on this patient's a traumatic brain injury and on the lack of a prior contributory and relevant medical history, and based on the neuropsychaitric and medical symptoms that developed subsequent to the injury, it is determined with a high degree of medical certainty that the patient's current disability was caused by the injuries he suffered on 2.27.08.

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Treatment
The patient should receive cognitive rehabilitative Psychotherapy, incorporating to it Neurotraining, with the purpose of enhancing his attention and cognitive enhancement. It should also include Psychotropic medications, i.e. stimulants as and when necessary.

Degree of Disability The patient suffers from a partial disability, reflected in reduced concentration and cognitive functions.

Permanency of Disability - Undetermined

Prognosis – Guarded for a full remission

I, Dr. Kuhn, being a psychiatrist duly licensed to practice in the State of New York, under the penalties of perjury, pursuant to CPLR, section 2106, do hereby affirm the content of the foregoing.

Daniel Kuhn, M.D.,
Board Certified Psychiatrist

Daniel Kuhn M.D., P.C.

Integrative Neuropsychiatric Services

Daniel Kuhn M.D., Psychiatrist, Diplomat of the American Board of Neurology and Psychiatry   Telephone: (212) 315-1755
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10.09.08

BRAIN ELECTRO-NEUROPHYSIOLOGICAL TESTING BATTERY
EEG, Quantitative EEG and Evoked Potentials

Patient's Name: Gabriel Steif
Patient's ID#: 879
DOT: 10.07.2008
DOB: 04.25.1937
DOA: 02.27.2008
SS# 076-36-0954
Sex: Male
Technician: L.Reid, R.EEG T.
Laterality: R

The decision to do a brain mapping battery is based on the fact that the patient suffered a closed head injury, had positive symptoms following it. It is done in order to locate and quantify the level of brain damage and dysfunction for a diagnostic assessment purpose.

Introduction to the Brain Mapping Battery
The following is a clinical diagnostic battery of neuro-physiological brain function tests that detect and measure brain dysfunction in neurological and neuropsychiatric disorders.

It consists of the following components:
1. Visual inspection of the raw EEG for Epilepsy and abnormal brain wave patterns.
2. Quantitative analysis of the EEG
3. Three Evoked Potential tests

The evoked potential tests look for delays in conduction of sensory pathways and tracts leading from one brain region brain to another. Abnormalities are usually indicative of damage and dysfunction in those pathways. The multimodal Evoked Potentials include Visual Evoked Potentials (VEP) recorded in response to left and right eye pattern reversal photic stimulation; Brainstem Auditory Evoked Potentials (BAEP) recorded in response to monaural clicks; Brainstem Somatosensory Evoked Potentials (SSEP) recorded in response to left and right median nerve stimulation.

All together this battery of tests shows areas of dysfunction in the brain and quantifies the degree of deviation from a normalized database. This allows for the detection and localization of brain

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pathology and/or dysfunctions.

The above mentioned tests are evaluated in relation to each other, thus providing a three dimensional global assessment of brain functions.

Furthermore, it provides information which may assist in the differential diagnosis and in the selection of treatment protocols and medications.

This battery is determined to be a valid clinical test by the criteria set in 1997 by the American Academy of Neurology, as demonstrated by the peer reviewed reference: "Conventional and Quantitative Electroencephalography in Psychiatry," John R. Hughes, M.D., Ph.D., E Roy John, Ph.D., J. Neuropsychiatry Clin. Neuroscience 11:2 Spring 1999.

While raw EEG has about a 0.3 reliability score, QEEG has a reliability score of 0.95. All EEG acquisition machines produced today are computerized and allow for quantitative measures to be performed on the recorded EEG. All EEG studies today are quantified. Therefore QEEG is no longer considered to be an experimental or novel technique. Its validity in the assessment of brain trauma and epilepsy and in assessing brain dysfunction in neuropsychaitric conditions is reflected in tens of thousands of peer reviewed publications on QEEG. Today, all scientific study of EEG records is done using computerized EEG machines and specialized programs.

Database Analysis of QEEG
The QEEG analysis utilizes the Neuroguide database. The NeuroGuide database has a 510K clearance by the FDA (August 2004 #K041263), as an indication that construction of the database has been scrutinized for good manufacturing practices (GMPs). It also signifies the legitimacy of marketing claims made concerning the database. It is based on 2,831 variables, and includes measures from some 625 normal individuals and over 5,000 clinical cases. The cross-validation and other scientific evaluations of the NeuroGuide database have been published in numerous peer reviewed journal articles.

The analysis is performed on EEG that is referenced in two different montages (measurement modes):

Linked Ear Montage: - which has the advantage of tracing regional abnormalities and which also generates a clinical discriminant score for TBI and a TBI severity Index.

Laplacian Montage: - which has the advantage of providing a better localization of focal abnormalities and precise measurements. (its references are neighboring measurement points and not distant locations like the ear lobes.)

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e two montages do not produce identical scores since they use differing points of reference (linked ears vs. surrounding electrodes).

Neuroguide analysis of QEEG - Between one and three minutes of artifact-free data was extracted from the digital EEG record. This extracted data was subjected to digital analysis and statistical analysis with the Neuroguide program to detect abnormal deviations from corresponding measurements of normal individuals of the same age. The analyses produced functional topographic brain maps and corresponding statistical tables that best summarize and display the analyzed data and the degree of their deviation from the norms.

LORETA Brain Mapping - also called **Low Resolution Brain Electromagnetic Tomography (LORETA)** - provides a precise localization of deep sources of abnormal current density.

Current density measurements reflect synchronized neuronal discharges. LORETA provides a precise localization of the origin of abnormal deep current source densities that are the sources of abnormal widely spread EEG activity on the surface of the brain.

LORETA measurements reflect the highly synchronized activity of neighboring neuronal populations. The measurements used in our analysis are given in standard deviation units Z-scores that indicate hyper or hypo excitability of neuronal activity for each measured region in relation to the normative database.

Multimodal Evoked Potentials - Visual Evoked Potentials recorded separately in response to left and right eye pattern reversal stimulation; Brainstem Auditory Evoked Potentials recorded in response to monaural clicks; Somatosensory Brainstem Evoked Potentials recorded in response to left and then right median nerve stimulation.

The purpose of doing this battery of tests and its value to the treatment outcome of the patient are:

1. To validate the diagnosis of Traumatic Brain Injury with objective findings and to assess to what extent there is an organic basis for the patient's complaints, and to what degree of severity.

2. To locate areas of weakness and strength in the organization and neurophysiological status of the patient's brain so as to bring about a more efficient and optimal design of neurotherapy.

3. To set a baseline of present level of brain dysfunction in order to be able to detect improvement a

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and recovery, or lack thereof, in the future and assess the prognosis of the patient.

Test Performed: Digital EEG
Quantitative EEG
Topographic Brain Mapping
Brainstem Auditory Evoked Potential (BAEP)
Pattern Reversal Visual Evoked Potential (PRVEP/LED)
Brainstem Somatosensory Evoked Potential (BSEP/SSEP)

Test Protocol: This EEG evaluation involves 20 minutes of eyes closed, resting, baseline digitally recorded EEG. Also included is up to three minutes of standard hyperventilation, a period of post-hyperventilation, eye opening and closing reactivity and a period of photic stimulation.

Testing Results

Raw EEG Findings:
The patient was alert and cooperative. There is a mild to moderate level of muscle artifact.

The record is moderately organized, with a predominant frequency of 8-9 Hz, poorly formed, moderately sustained with low to medium voltage.

Alpha cessation was normal with eye opening.

No epileptic activity, sharp waves were elicited.

Spikes were seen in the T5, O1 areas in the left posterior region suggesting cortical dysfunction there.

Could not do Hyperventilation due to irregular heartbeat. Normal response to photic stimulation.

Current Medications: No medications three days prior and during the time of the test.

Quantitative EEG:
The measurements that contribute most to the determination of brain damage, diffuse axonal injury and brain dysfunctions are: abnormally high or low coherence and phase measurements (abnormal changes in degree of synchrony between regions), LORETA findings of abnormal deep current

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sources (LORETA), positive clinical discriminants, asymmetry of power between homologous regions, and abnormal frequency distribution).

EEG Epoch selection - selection for this quantitative spectral analysis was taken from the raw EEG records of one minute.

Reliability of Test Results - This test is found to be reliable
Split half reliability score: 0.97
Test-retest reliability score: 0.92

Clinical Discriminant Scores
This measurement functions as a diagnostic aid by calculating the probability of fitting an individual QEEG profile to profiles established for certain clinical groups.

Neuroguide Database Clinical Discriminant Score for Traumatic Brain Injury:
TBI Probability index – 99.5%
TBI Severity Index – 2.78, reflecting a mild level of neurological symptom severity.

For reference see Thatcher et al; J. Neuropsychiatry and clinical Neuroscience., 13,(1): 77-87, 2001.(The score is scaled from 1 to 10.).

Spectral Analysis
Absolute power measurements -
The z-scored absolute power measurements show low power in the occipital region in Delta and Theta wave bands, peaking in the left posterior temporal area (T5) and left occipital area.

There is an elevation of power in the 9 Hz frequency (alpha) in the left prefrontal and fronto-lateral region as well as elevation of 12 Hz amplitude. In the left fronto-lateral region.

There are also high concentrations of High Beta waves in the left occipital region. And a high beta focus in Cz - the mid central region (24-30 Hz waveband.) .

Coherence measurements -
There was found to be significant hypocoherence bilaterally in the central, parietal and occipital regions across all frequencies, which is also reflected in the significant increase of phase lag in the same regions as well as in anterior region,. There data support a disturbance in connectivity between both hemispheres in those regions.

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Coherence Measurements - Definitions
Coherence - The percentage of brain wave activity that is time-related between two locations. The normal coherence between all regions is around 60%.
Hypercoherence indicates hyper synchrony between two locations or regions and a loss of local, differentiated activity.
Hypocoherence indicate poor synchrony, reflecting impairment in the connection between two locations or regions.
Changes in coherence are seen frequently in cases of Traumatic Brain Injury and Post Concussion Syndrome.

LORETA
Low Resolution Electromagnetic Tomography shows the following areas of abnormal deep source currents -
1. There was a low current density of 1-4 Hz waves by -2.67 s.d. in the Middle Temporal Gyrus of the Right Temporal Lobe.
2. There was also a low current density of 5-11 Hz waves by -2.22 s.d. in the Inferior Temporal Gyrus of the Left Frontal Lobe.
3. There was a high current density of 23-25 Hz waves by 2.00 s.d. in the Lingual Gyrus of the Occipital Lobe.
4. There was a high current density of 22-30 Hz waves by 2.14 s.d. in the Fusiform Gyrus of the Left Occipital Lobe.

Those are the deep sources contributing to the abnormal distribution of EEG in adjacent areas.

Summary of Results of Evoked Potential tests
(for full tabular and visual data, please review the individual report on each test.)

Brainstem Auditory EP:
There are no conduction delays in either the left or right auditory stimulation tests, and there is no evidence of eighth nerve or brainstem damage bilaterally. No delay in interpeak latency 1-3 and 3-5 or 1-5.

Pattern Reversal Visual EP:
Right eye stimulation bilateral occipital evoked responses were delayed - 110.16 and 113.28 msec in left and right occipital measurement points respectively.
Left eye stimulation bilateral occipital evoked responses were delayed, 115.23 and 117.19 msec in left and right occipital measurement points bilaterally.
The above data support the diagnosis of diffuse axonal injury.

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Brainstem Somatosensory EP:
Right ear stimulation shows a delay in Peak I – (2.02 msec; the norm is <2.0 msec), and a delay in the interpeak III-V (2.39 msec; the norm is <2.3 msec.)

It suggests a possible damage or dysfunction to the right acoustic nerve and to the lower right brainstem.

There were no conduction delays in the stimulation of the left side, and its scores are within normal limits. .

Brainstem Somatosensory EP:
There is a conduction delay in the left side median nerve stimulation in the P22 wave (the Thalamic level on the right side) No conduction delays are seen in the right side stimulation.

Summary of Findings and Conclusions

This is an abnormal record with findings strongly supporting the diagnosis of a traumatic brain injury and Diffuse Axonal Injury.

There is indication that several areas were affected by the impact he suffered, as seen in the multiple foci of abnormal source density of EEG in the LORETA mapping.

The scores show a significant disturbance in the connection between the left and right hemispheres as expressed in the significant hypocoherence and increased phase lag between the hemispheres. It is most significant in the central and posterior regions.

Spectral power analysis shows an elevation of power (mean amplitude) alpha and low beta frequencies ((and 12 HZ.) in the left prefrontal and fronto-lateral region. There is a significant abnormal cortical function in the left occipital and posterior temporal regions with a significant excess of beta and high beta, and a significant decrease of delta and theta power there, together with the finding of multiple spikes in the left posterior temporal region.

The Visual evoked potential shows significant conduction delays in visual pathways, which support the diagnosis of a Diffuse Axonal Injury in both hemispheres.

The Brainstem EP shows conduction delay on the right thalamic level (Left median nerve stimulation.)

The brainstem evoked potential shows a conduction delay of Peak I, and increased interpeak I-III in the right side. It suggests a dysfunction in the right lower brainstem level.

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The clinical discriminant score for TBI is positive and supports the diagnosis of a Traumatic Brain Injury. The severity of neuropsychaitric symptoms is assessed as mild from a clinical point of view.

Overall, there is an indication that the patient has suffered a diffuse axonal injury, meaning a brain damage, which affects the brain function on both cortical and subcortical level. It affects the connectivity between most regions, and is particularly disturbed in the posterior regions.

The frontal left lobe damage suggests that the patient may be have impairment in attention, concentration and ability to sustain his attention and divide it between more than one task. Furthermore, he is prone to dysphoric mood (depression) and impaired executive functions and poor ability to perform complex tasks due to his frontal lobe dysfunction.

This test battery establishes a causal relationship between the patient's current cognitive dysfunction and their Traumatic Brain Injury.

Considering the fact that the patient was able to function well prior to the above mentioned injury, and reports a decline in performance skills and productivity since the accident, it is correct to assume that if the report is correct, the TBI is the cause of the patient's current disability.

It is important to note that any additional brain concussion in the future may cause the patient major neurological and mental deterioration due to a diminished neuronal reserve.

Also, studies show that the chances for an early onset of dementia are higher in such patients due to their diminished neuronal reserve.

Daniel Kuhn M.D.,
Board Certified Psychiatrist.

EC = 1:07 - 5:35
5:55 - 15:00

Integrative Neuropsychiatric services of New york
Daniel Kuhn, M.D.

Technician's observations and comments on EEG

Name Steif, Gabriel DOT 10/7/08 DOB 4/25/37 DOA 2/27/08 Handed: (R)/L

EEG# 879 Problem Hit by bus, Head injury Meds _____

CE EEG Epochs _____; _____

Condition: (Alert) / Lethar / Stupor / Sleep / Confused / Agitated /
Restless / (cooperative) / drowsy / awake -
Eye open/closed Alpha activ. cessation - (Normal/missing)

Artifacts: mvmt/(muscle)/sweat/electrode/EKG/drug/60 Hz.

Description of EEG(circled): mod/well/(poor organized); PDR 7 (8, 9,)
10, 11, 12 Hz; Symm; well/(poor)/mod (formed;) mod/well//poor
(sustained;) (low/med/)high voltage; lvf: ac/diff.

HV: normal/abnormal _____   PS: _____ normal/ abnormal Symm/ asymm/
PD/ Photoconvul _____   Sleep spontaneous/induced I II III IV.
Could not HV - (Irregular Heartbeat)

REM symm/asymm, vertex, spindless/k Complex _____
Variants: R/L/Bilat/frontal/ ant/mid/[pst/temp/occip/pariet/cent;
mod/reg/occas/infreq/rare; 1/2,1,2,3,4,5,6,7 Hz, /low,(med,high)
colt; polimorphic, monomorphic, rythmic- single,poly,sharp,spike,
generalized, suspected, with/without clinical activity. 1b O,7

Multimodal Evoked Potential
VEP _____   BAER _____   SSEP _____

Technician Name Laurence Reid Comments _____

Discriminant scores _____

COmments on Raw EEG _____

See the attached narrative report for Physician's impressions and
conclusions regarding EEG, QEEG and Evoked POtentials.

Technician Sign. Laurence Reid R.EEGT.   For Daniel Kuhn, M.D.

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f New york

               DOB: 04/25/1937
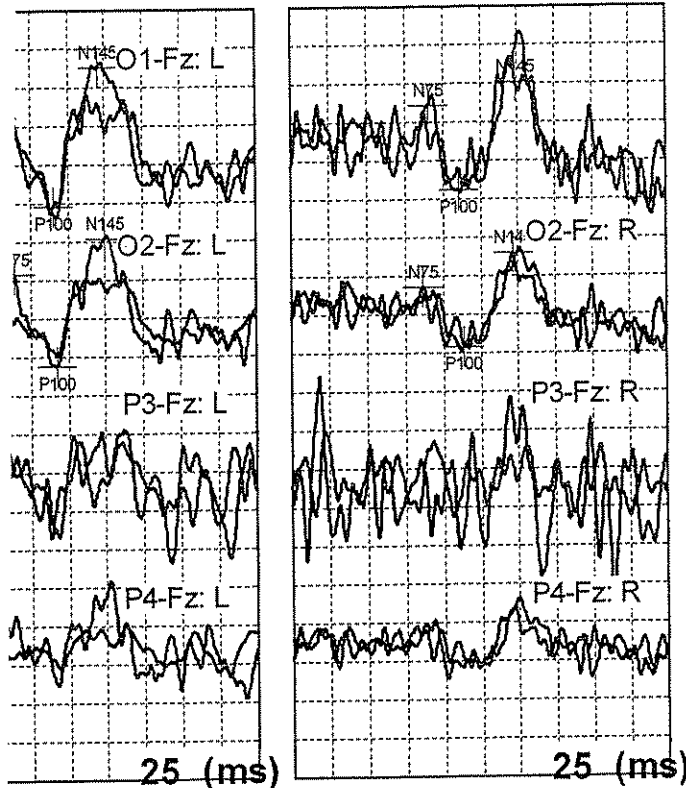   Sex: Male

on EEG

Handed: (R)/L

sed / Agitated /
ke -
- Normal/missing

0 Hz.

ed; PDR 7, 8, 9,
mod/well//poor

mal Symm/ asymm/
ced I II III IV.

cip/pariet/cent;
, /low,med,high
oly,sharp,spike,
ivity.

	N145 (ms)	N75-P100 (μV)
5	148.44	11.00
3	146.48	7.96
3	145.81	11.65
)	149.61	11.95

AvgCnt	Reject (%)	RepRate	Gain (μV/div)
44	0.0	2.11	5.00
44	0.0	2.11	5.00
44	0.0	2.11	15.00
44	0.0	2.11	5.00
48	0.0	2.11	5.00
48	0.0	2.11	5.00
48	0.0	2.11	5.00
48	0.0	2.11	5.00
22	0.0	2.11	5.00
22	0.0	2.11	5.00

impressions and
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aniel Kuhn, M.D.

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Integrative Neuropsychiatric services of New york
Daniel Kuhn, M.D.

Technician's observations and comments on EEG

Name Steif, Gabriel DOT 10/7/08 DOB 4/25/37 DOA 2/27/8 Handed: (R)/L

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HV: normal/abnormal_____ PS:_____ normal/ abnormal Symm/ asymm/
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Could not HV - (Irregular Heartbeat)
REM symm/asymm, vertex, spindless/k Complex_____
Variants: R/L/Bilat/frontal/ ant/mid/[pst/temp/occip/pariet/cent;
mod/reg/occas/infreq/rare; 1/2,1,2,3,4,5,6,7 Hz, /low,med,high
colt; polimorphic, monomorphic, rythmic- single,poly,sharp,spike,
generalized, suspected, with/without clinical activity. 1b O, Ts

Multimodal Evoked Potential
VEP_____ BAER_____ SSEP_____

Technician Name Laurence Reid Comments_____

Discriminant scores_____

COmments on Raw EEG_____

See the attached narrative report for Physician's impressions and
conclusions regarding EEG, QEEG and Evoked POtentials.

Technician Sign. Laurence Reid R.EEGT.   For Daniel Kuhn, M.D.

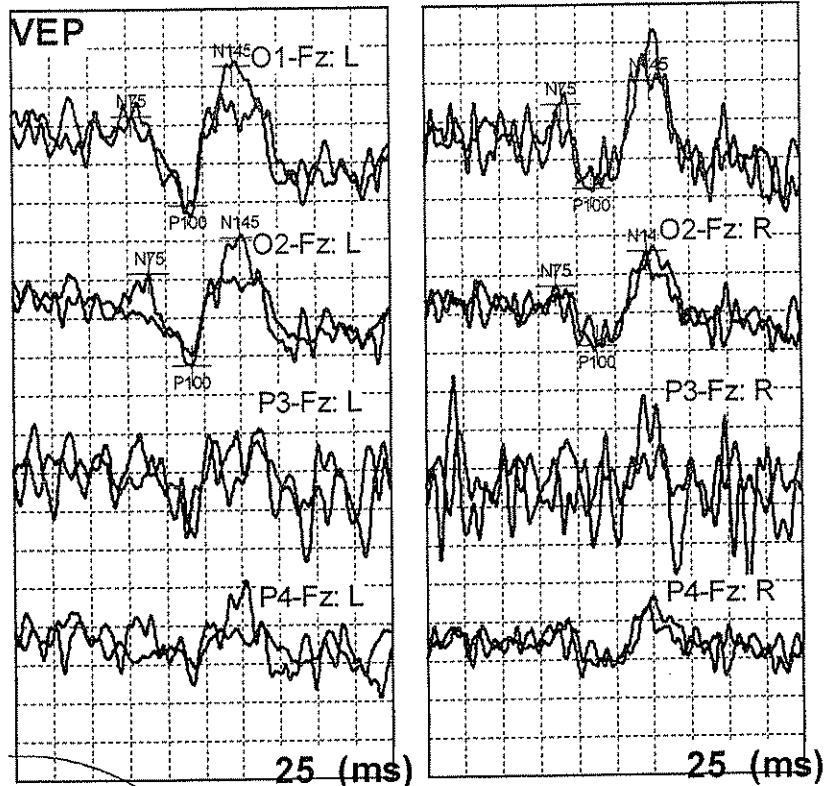**Patient:**   Steif, Gabriel   **Test Date:**   10/07/2008   **p.**   **2**

P3-Fz: L	LED	22	0.0	2.11	5.00
P4-Fz: L	LED	22	0.0	2.11	5.00
O1-Fz: R	LED	51	0.0	2.11	5.00
O2-Fz: R	LED	51	0.0	2.11	5.00
P3-Fz: R	LED	51	0.0	2.11	5.00
P4-Fz: R	LED	51	0.0	2.11	5.00

Patient History:

Medications:

Findings:

Conclusions:

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Patient:	Steif, Gabriel	DOB:	04/25/1937
ID#:		Sex:	Male
SS#:			

VEP

Trace	N75 (ms)	P100 (ms)	N145 (ms)	N75-P100 (μV)
O1-Fz: R	89.84	110.16	148.44	11.00
O2-Fz: R	86.33	113.28	146.48	7.96
O1-Fz: L	78.52	115.23	145.31	11.65
O2-Fz: L	89.06	117.19	149.61	11.95

Trace Name	Type	AvgCnt	Reject (%)	RepRate	Gain (μV/div)
O1-Fz: R	LED	44	0.0	2.11	5.00
O2-Fz: R	LED	44	0.0	2.11	5.00
P3-Fz: R	LED	44	0.0	2.11	15.00
P4-Fz: R	LED	44	0.0	2.11	5.00
O1-Fz: L	LED	48	0.0	2.11	5.00
O2-Fz: L	LED	48	0.0	2.11	5.00
P3-Fz: L	LED	48	0.0	2.11	5.00
P4-Fz: L	LED	48	0.0	2.11	5.00
O1-Fz: L	LED	22	0.0	2.11	5.00
O2-Fz: L	LED	22	0.0	2.11	5.00

An abnormal record bilaterally

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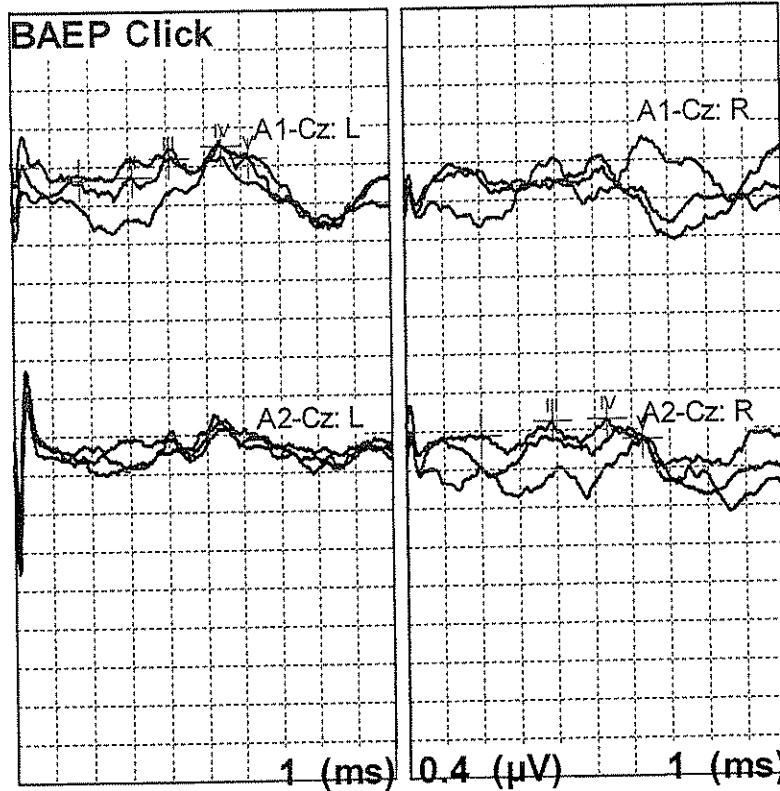
Patient:	Steif, Gabriel	DOB:	04/25/1937
ID#:		Sex:	Male
SS#:			

BAEP Click

Trace	I (ms)	II (ms)	III (ms)	IV (ms)	V (ms)	I-III (ms)	III-V (ms)	I-V (ms)	Amp Dif (µV)
Norm	2.0		<4.5		<6.2	<2.4		<4.5	
A2-Cz: R	2.02		3.89	5.33	6.28	1.88	2.39	4.27	
A1-Cz: L	1.78	3.13	4.11	5.47	6.20	2.33	2.09	4.42	
L-R Norm						<0.28	<0.32	<0.33	
L-R	0.23		0.22	0.14	0.08	0.45	0.30	0.16	

Trace Name	Side	Stime Type	Stmr Type	Intensity L/R (db)	Threshold L/R (db)	Mask (db)	Polarity	PW (µs)	AvgCnt	Reject (%)	RepRate	Gain (µV/div)	Hicut (Hz)
A1-Cz: L	Left	Click	Phones	70/Off	10/10	Off	Rare	100	1537	0.0	21.10	0.40	3000.00
A2-Cz: L	Left	Click	Phones	70/Off	10/10	Off	Rare	100	1537	0.0	21.10	0.40	3000.00
A1-Cz: R	Right	Click	Phones	Off/70	10/10	Off	Rare	100	528	0.0	21.10	0.40	3000.00
A2-Cz: R	Right	Click	Phones	Off/70	10/10	Off	Rare	100	528	0.0	21.10	0.40	3000.00
A1-Cz: R	Right	Click	Phones	Off/70	10/10	Off	Rare	100	1035	0.0	21.10	0.40	3000.00
A2-Cz: R	Right	Click	Phones	Off/70	10/10	Off	Rare	100	1035	0.0	21.10	0.40	3000.00
A1-Cz: R	Right	Click	Phones	Off/70	10/10	Off	Rare	100	865	0.0	21.10	0.40	3000.00

Patient: Steif, Gabriel   **Test Date:**   10/07/2008   **p.   2**

R A2-Cz:	Right	Click	Phones	Off/70	10/10	Off	Rare	100	865	0.0	21.10	0.40	3000.00
R A1-Cz: L	Left	Click	Phones	70/Off	10/10	Off	Rare	100	1281	0.0	21.10	0.40	3000.00
A2-Cz: L	Left	Click	Phones	70/Off	10/10	Off	Rare	100	1281	0.0	21.10	0.40	3000.00
A1-Cz: L	Left	Click	Phones	70/Off	10/10	Off	Rare	100	677	0.0	21.10	0.40	3000.00
A2-Cz: L	Left	Click	Phones	70/Off	10/10	Off	Rare	100	677	0.0	21.10	0.40	3000.00

Patient History:

Medications:

Findings:

Conclusions:

10/07/2008

Patient:	Steif, Gabriel	DOB:	04/25/1937
ID#:		Sex:	Male
SS#:			
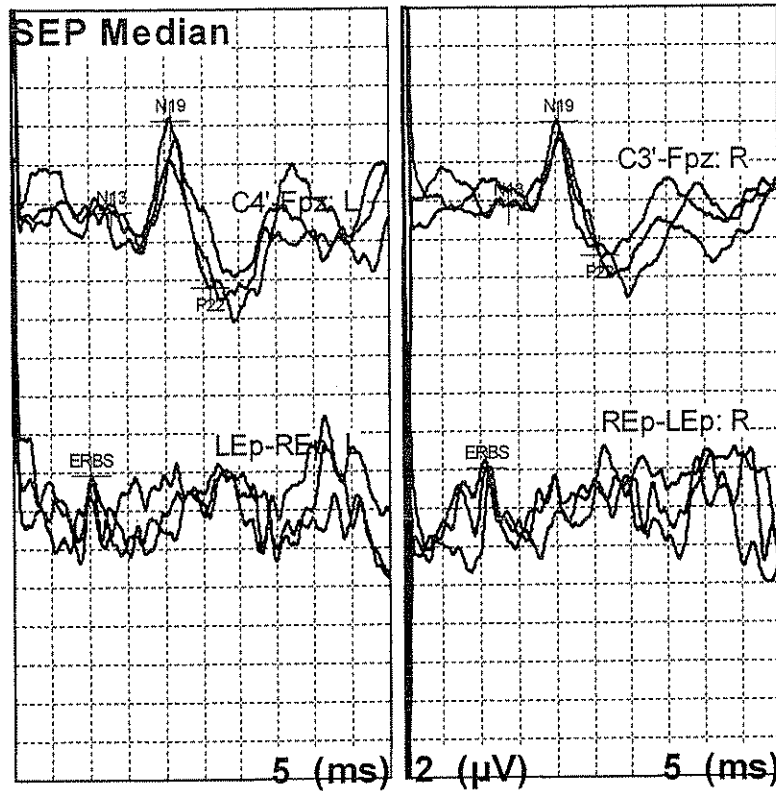
SEP Median

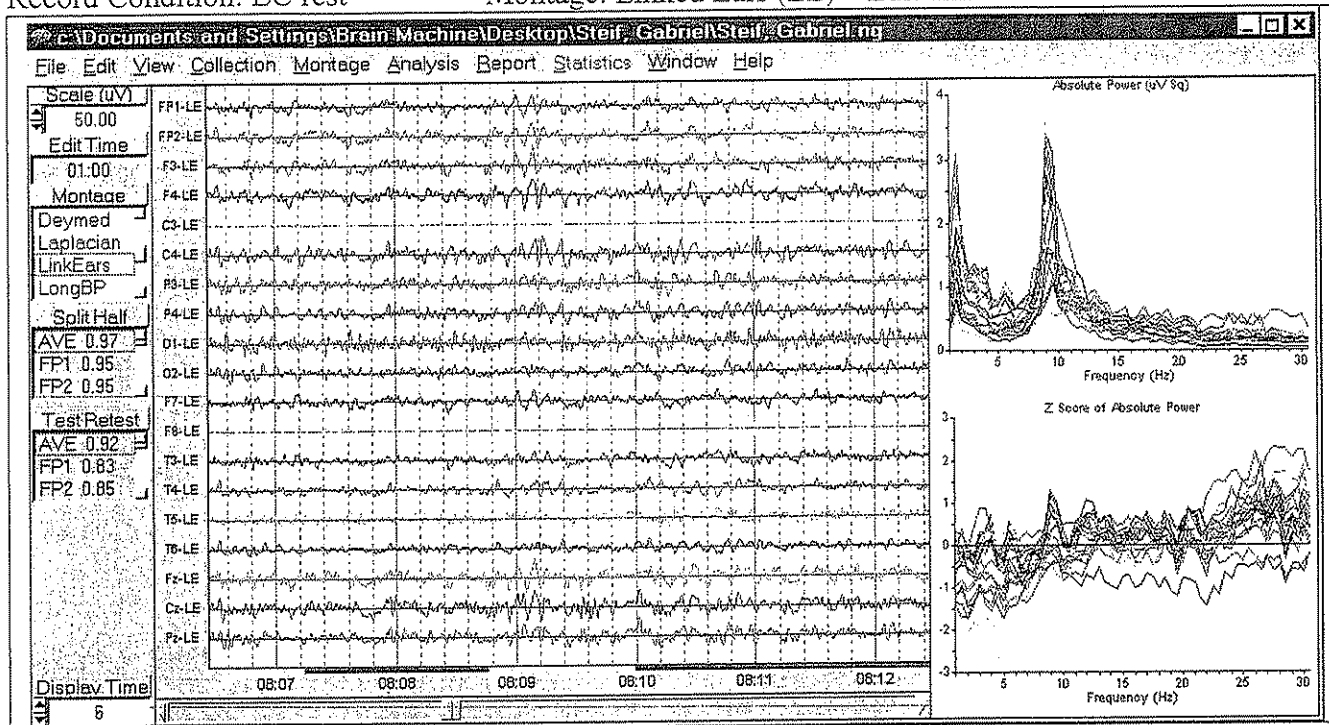| Trial	ERBS (ms)	N13 (ms)	N19 (ms)	P22 (ms)	ERBS-N13 (ms)	N13-N19 (ms)	N19-P22 (ms)	ERBS-N13 (μV)
Norm	19							
3 L	10.31	13.05	20.94	26.17	2.73	7.89	5.23	0.89
4 R	10.78	13.75	20.39	25.94	2.97	6.64	5.55	0.89
L-R Norm	0.2	0.2	0.2	0.2				
L-R	0.47	0.70	0.55	0.23	0.23	1.25	0.31	0.00

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EEG ID: 879   Recording Date: 10.07.2008   D.O.B.: 04.25.1937
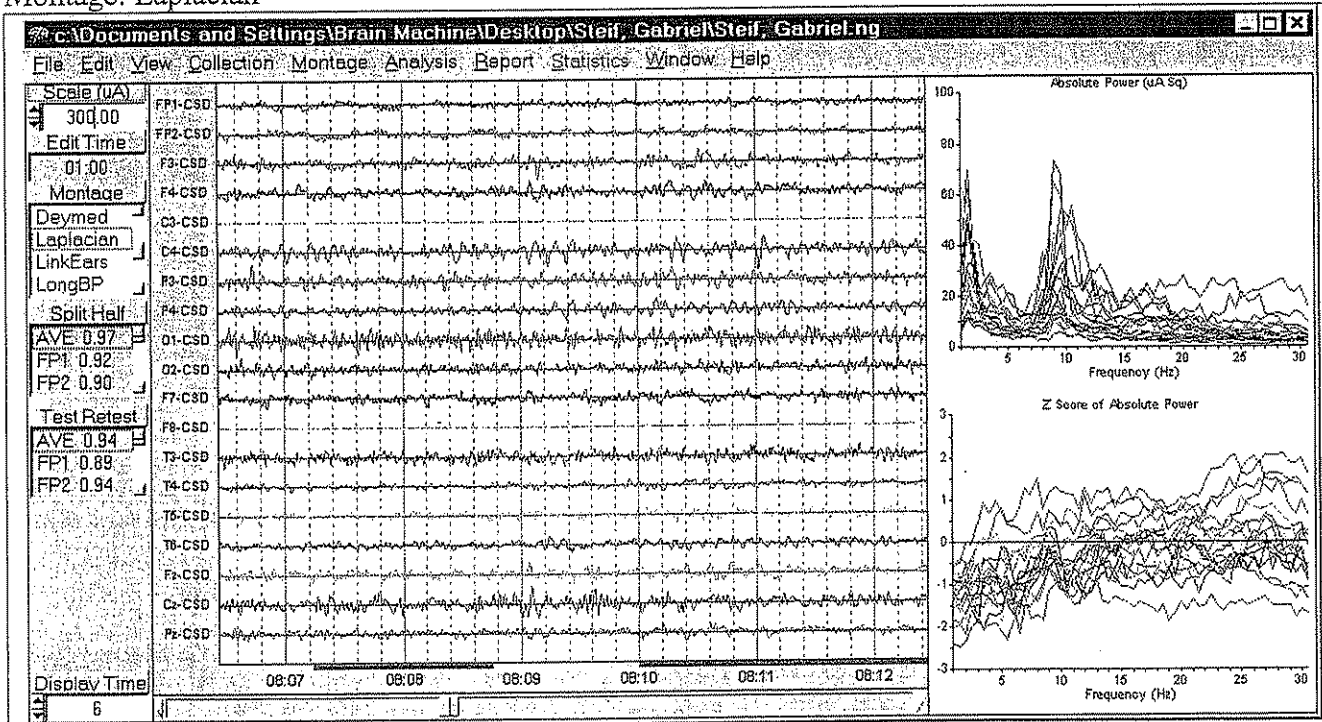Record Condition: EC rest   Montage: Linked Ears (LE)   Edit time: 01min 00sec
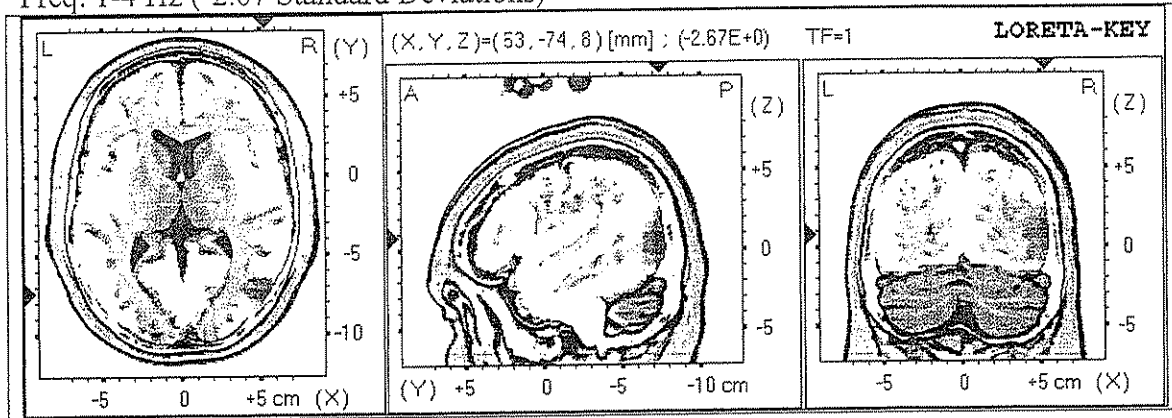

Montage: Laplacian

EEG ID: 879   Recording Date: 10.07.2008   D.O.B.: 04.25.1937

Freq: 1-4 Hz (-2.67 Standard Deviations)

(X,Y,Z)=(53,-74,8)[mm] ; (-2.67E+0)   TF=1   LORETA-KEY

Talairach Anatomical Location:

| 1st Best Match (d=1mm) |
| Brodmann area 39 |
| Middle Temporal Gyrus |
| Right Temporal Lobe |

Freq: 5-11 Hz (-2.22 Standard Deviations)

(X,Y,Z)=(-52,38,-13)[mm] ; (-2.22E+0)   TF=6   LORETA-KEY

Talairach Anatomical Location:

| 1st Best Match (d=3mm) |
| Brodmann area 47 |
| Inferior Frontal Gyrus |
| Frontal Lobe |

EEG ID: 879   Recording Date: 10.07.2008   D.O.B.: 04.25.1937

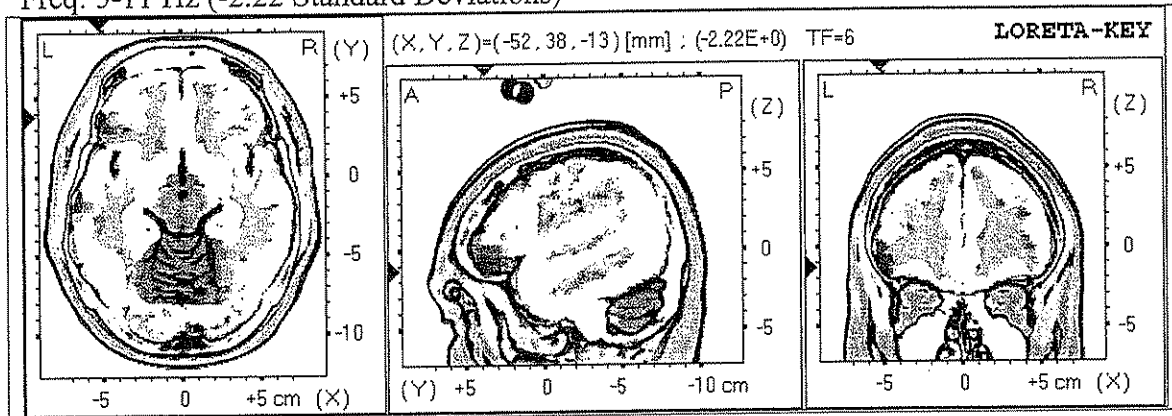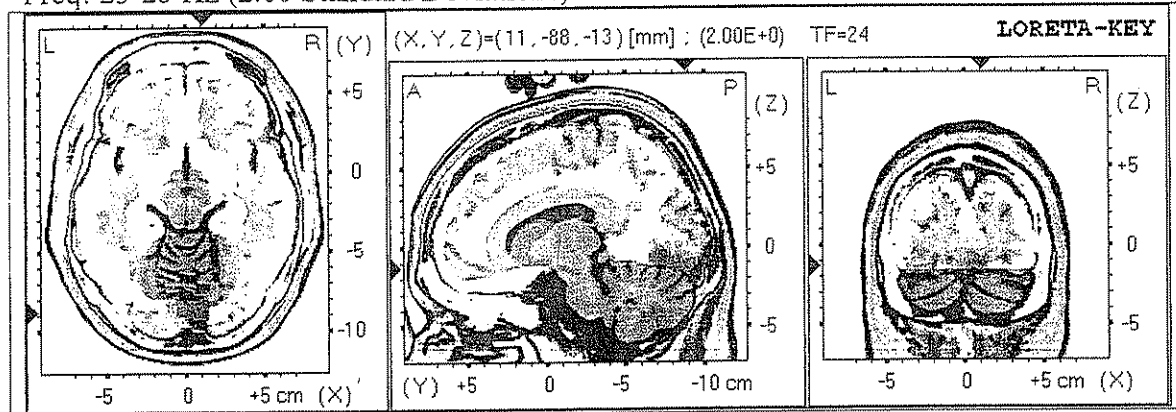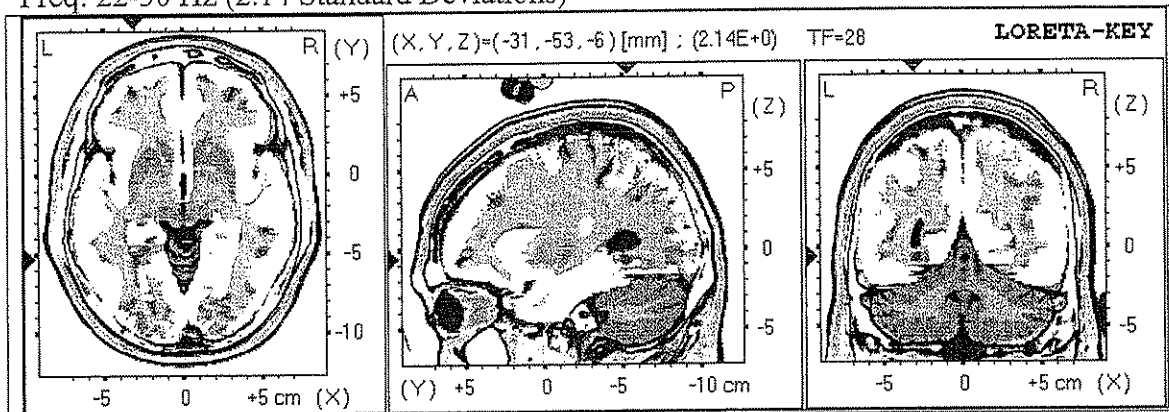Freq: 23-25 Hz (2.00 Standard Deviations)

Talairach Anatomical Location:

1st Best Match (d=5mm)
Brodmann area 18
Lingual Gyrus
Occipital Lobe

Freq: 22-30 Hz (2.14 Standard Deviations)

Talairach Anatomical Location:

1st Best Match (d=8mm)
Brodmann area 37
Fusiform Gyrus
Leeft Occipital Lobe

Montage: LinkEars

EEG ID: 879

Subject Information

Name: Gabriel Steif

Subject ID: 879

Date of Birth: 04/25/1937

Age: 71.45

Gender: Male

Handedness: Right

EEG ID: 879

Date of Test: 10/07/2008

Time of Test:

Technician: L. Reid

Eyes Condition: Eyes Closed

Doctor: Daniel Kuhn, M.D.

Medication: None three days prior to test.

Comments: Neuroguide Deluxe 2.5.1

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Montage: LinkEars

EEG ID: 879

Technical Information

Record Length: 21:33

Edit Length: 01:00

Reliability:

	Split Half	Test Retest
Average	0.97	0.92
FP1	0.95	0.83
FP2	0.95	0.85
F3	0.98	0.89
F4	0.95	0.89
C3	0.97	0.97
C4	0.97	0.89
P3	0.99	0.98
P4	0.97	0.98
O1	1.00	0.96
O2	0.98	0.96
F7	0.97	0.85
F8	0.96	0.88
T3	0.98	0.94
T4	0.91	0.90
T5	0.99	0.99
T6	0.96	0.98
Fz	0.97	0.90
Cz	0.95	0.93
Pz	0.99	0.96

Sampling Rate: 200

Collection Hardware: Cadwell

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